

No. 2
- 43
17-39
K37823

FILED APR 17 1948

Registration District No. 149

Primary Registration District No. 1002

State File No. _____

Registrar's No. 1439

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs. 49 min.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48
(c) City or town K.C. (If outside city or town limits, write "RURAL") 3
(d) Street No. 2310 So. 8th. (If rural, give location) 8
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Wallace George Malczak

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced W. 13. 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 3 - 30 - 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. 49 min.

9. Birthplace K.C. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Newborn

11. Industry or business _____

12. Name Wallace V. Malczak
13. Birthplace Philadelphia Pa. (City, town, or county) (State or foreign country)
14. Maiden name Mary Wheeler
15. Birthplace K.C. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant mother
(b) Address 2310 So. 8th. K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 2 48 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Q. Wink & Tobin, Co.
(b) Address 20 W. Linwood

19. (a) 4-1-48 (Date received local registrar) (b) Asteradine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 31 year 1948 hour 2 minute 35 a.m.

21. I hereby certify that I attended the deceased from 3-30-48 to 3-31-48
that I last saw him alive on 3-31-48 and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth (5 1/2 km) of placenta Duration _____
Due to Cause unknown

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Asteradine Holmes (M.D. or other) _____ Address 405 So. Grand St. Date signed 3/3/48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~of~~.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed... *Howard W. Farmer*

Licensed Embalmer No. *4134*

P. O. Address... *Barnes City Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

FILED MAY 7 1948

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Wallace George Walczak

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

{ 13. Birthplace..... (City, town, or county) (State or foreign country)

{ 14. Maiden name.....

{ 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-1-48 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2310 S. 8th
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
that I last saw him..... alive on....., 19.....
and that death occurred on the date and hour stated above.
immediate cause of death.....

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other)
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-12940